

higher LDL cholesterol (13.7 vs. 12.8 mg/dL, $p=0.07$). By contrast, there were no differences between the two groups as regards duration of HIV infection, time of exposure to ARVs, (whether considered as a whole or by class), us-CRP, or IL-6. Of the 45 patients with an abnormal CACS, 41 (91.1%) had FRS <20 and would not have been eligible for cardiovascular prevention treatment. These 41 patients represented 22.9% of all patients with FRS <20 . None of the 5 patients with CACS >300 had been identified as high cardiovascular risk patients by FRS.

Conclusion: In HIV-infected patients, CACS identified presence of coronary atherosclerosis in 22.9% of patients who were deemed to be at low to intermediate cardiovascular risk based on FRS.

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Do platelet activity assessment and genotyping help predict outcome in real world management of patients with ACS?

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Purpose: it has been postulated that outcome of poor metabolizers of clopidogrel may be worse in ACS patients. Data about the interest of assessing platelet reactivity and genotyping in predicting outcome of patients with ACS taking clopidogrel is still conflicting.

Methods: Prospectively, 120 successive patients (76.7% men, mean age=60+/-12.2 years) with ACS 45% STEMI) were included. Patients were excluded if not eligible to clopidogrel therapy or to the platelet activity test. Patients were managed according to ESC guidelines. Platelet activity was assessed by a VerifyNow P2Y12 test more than 24h after a 600mg clopidogrel loading dose. DNA was extracted for genotyping of CYP1A1 and CYP2C19 (*1,*2,*3). MACE (death, infarction, stroke, coronary revascularization) was assessed at 6 months.

Results: poor platelet inhibition (PRU>230) was noted 54 (46.6%) patients. CYP1A1 and CYP2C19 low metabolizers (homo and heterozygosis) were respectively 23.1% and 37.5%. MACE at 6 months was noted in 15 (12.5%) patients. No significant correlation was found between MACE and platelet reactivity test nor MACE and genotypes CYP1A1 and CYP2C19. combination of platelet response and resistant genotypes didn't help to predict MACE.

Conclusion: despite the high rates of poor responders to clopidogrel in this study, assessed by the verify now P2Y12 test and by genotyping (CYP1A1 and CYP2C19), no correlation has been found with MACE at 6 months.

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"Litigious" exercise training: contribution of myocardial scintigraphy

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Introduction: In front of an important request for examination of myocardial scintigraphy following a test of "litigious" effort, we are propose to complete this work futurology with an aim of answering the question suggested in title, in referent with the results of the myocardial tomoscintigraphy. Materials and methods: Between January 2008 and May 2010, we investigate 186 consecutive patients presenting of the coronary risk factors addressed for myocardial tomoscintigraphy in front of a test of litigious effort on the electric level carried out within the framework of a search for quiet ischemia. Within the service of nuclear medicine all the patients profited from a test of effort according to the protocol of Bruce, followed by an examination tomoscintigraphy with the MIBI. In the event of a disorder perfusionnel with the myocardic scintiscanning, the patient is taken again for an examination of rest.

Results: There are 105 women and 81 men whose Middle Age is respectively of 57.4 ± 9.3 years and 59.6 ± 8.2 years. The patients are diabetics in 66% of the cases, 78% are women, hypertensive in 53%. The other risk factors are also found with variable proportions. The tests of effort carried out were all maximum. Four 92% of the tests of effort are negative clinically and "wrongfully positive" electrically. The TSM of these patients is normal in 100% of the cases. In 8% of the cases, the test of effort is positive electrically,

the TSM is normal not detecting any disorder perfusionnel in 73% of the cases, for the 4 other patients it objectifies disorders perfusionnels; the coronarography of these patients is pathological but without significant lesions except for a patient. This last had in fact finished its test of effort by a non-constant ventricular tachycardia suggesting a severe ischaemia confirmed with the coronarography.

Conclusion: A quite critical reading of under misalignment of the segment ST during a test of effort diagnoses in particular at the time of the search for a quiet ischemia, can avoid the recourse to other investigations

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Copeptin has a good negative predictive value in negative troponin I patients for ruling out an acute myocardial infarction in the emergency department

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Purpose: the aims of this study were to evaluate the novel biomarker copeptin in combination with troponin I (cTnI), in patients with chest pain presenting to the emergency department (ED), and to determine whether copeptin may allow for a rapid rule out of acute myocardial infarction (AMI). Previous data showed that combined measurement of copeptin and troponin T (cTnT) improved diagnostic performance for rapid rule out of AMI.

Methods: in 97 patients presenting to the ED with suspicion of AMI, we performed at admission, a conventional cTnI assay and a novel copeptin assay.

Results: of 97 patients, 44 (45.4%) had the final diagnosis of AMI, 11 (11.3%) of unstable angina and in 42 (43.3%) an acute coronary syndrome (ACS) could be excluded. Patients with AMI, had copeptin levels higher than patients with non ACS (20.12 vs 8.97 pmol/l $p<0.001$). At admission, the area under curve (AUC) of the receiver-operating characteristic (ROC) curve for the association cTnI / copeptin was not higher than AUC of cTnI (respectively 0.93 vs 0.89; $p=0.177$). In 60 patients with negative cTnI ($<0.044 \mu\text{g/L}$), copeptin ($<14 \text{ pmol/L}$) may allow to rule out AMI with sensitivity of 91.0% and negative predictive value (NPV) of 97.4%.

Conclusions: conversely to what has been demonstrated for cTnT, no significant difference in AUC was found when Copeptin/cTnI was compared to cTnI alone. This can be explained by the limited set of patients and the relative good result of cTnI AUC. Only combined use of copeptin in negative cTnI patients might help in ruling out AMI because of its good NPV and hence improve triage of patients presenting with chest pain in ED.

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The myocardial infarction of the young subject. Moroccan experience

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Purpose: The aim of this work is to study the specific epidemiological, clinical, angiographic and evolving myocardial infarction (MI) of the young subject.

Materials and methods: It is a descriptive retrospective study ruled in the two services of cardiology of the UHC Mohammed VI de Marrakech from January 2005 to October 2009. We included the patients admitted for MI and paired them in two groups: group1 composed of young patients under 45 years for men and 55 years for women, and group 2 of old patients beyond these age limits. Patients in both groups were investigated focusing in epidemiological analysis of cardiovascular risk factors, an ECG, a biological assessment and a Doppler ultrasound cardiac examination (TTE). The coronarography wasn't realized in all cases.

Results

	Group 1 N=30	Group 2 N=30	Value of P
Average age (years)	44.5±4,2	56,7±6,3	<0,01
Smoking	67%	64%	NS
Dyslipidemy	50%	27%	0,01
Diabetes	37%	39%	NS
Hypertension	13%	22%	0,01
Inaugural MI	83%	34%	<0.001
MI occurring at rest	97%	57%	<0.001
Anterior topography	70%	55%	<0.05
MI none Q	37%	17%	0.01
Normal TTE	27%	15%	<0.01
Dilatation of LV	3%	48%	<0.001

LV: left ventricle

The coronarography was realized in 10 cases of group 1 and 14 of group 2. It visualized especially impairment mono tronculaire in group 1, by cons multitronculaires injuries are frequently encountered in group 2. The hospital mortality was lower in young compared with older subjects.

Conclusion: The MI of the young subject is inaugural in the majority of cases and occurs especially at rest. Smoking and dyslipidemy are the independent factors of risk. The coronary lesions are non significant or readily mono tronculaires.

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Acute coronary syndrome in patients with diabetes: comparative series of 202 patients with and 250 patients without diabetes

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Introduction: Acute coronary syndrome (ACS) is common in diabetics and severe, the severity of coronary lesions and multiplying cardiovascular risk are likely to role in this adverse trend.

Objectives: The aim of this study was to determine the clinical and angiographic characteristics, treatment and development of ACS in diabetics (D) compared to nondiabetic (ND).

Methods: From January 2010 through April 2011, 452 patients with ACS were hospitalized in the cardiology department of the CHU Ibn Rochd in Casablanca Morocco, they included 202 D and 250 ND.

Results: Comparison of these two groups showed a younger age with a mean age of 51.4 years and a higher percentage of men (59%) among the D, hypertension was more frequent in D, while smoking was frequent in both groups.

Hospitalization was the reason for ACS without ST segment elevation in 54.3% in the D group versus 43.8% in the ND group (p=0.03) and for ACS with persistent ST segment elevation in 45.6% in the D group versus 56.1% in the ND group (p=0.02).

Coronary angiography showed: Table I

Table I – results of coronary angiography

	Diabetic patients	Nondiabetic patients	p value
normal coronary angiogram	13%	28%	0.002
single vessel coronary diseases	24%	42%	0.008
two-vessel coronary disease	27%	19%	0.15

multivessel coronary artery disease	35%	11%	0.00001
long coronary disease	69%	28%	0.0001
distal coronary disease	41%	19%	0.0001
anterior interventricular artery disease	49%	54%	0.449
left circumflex artery disease	19%	20%	0.9
right coronary artery disease	32%	26%	0.34

The syntax score calculated in the D was above 33 in 38.5% versus 11.4% in the ND, treatment was similar in both groups, 209 patients underwent myocardial revascularization, and its method (thrombolysis or coronary angioplasty or coronary artery bypass graft) did not differ by group. Neither hospital mortality nor other complications differed between the two groups.

Conclusion. The ACS in diabetics occurs at a younger age with a male predominance, coronary lesions are more extensive, more severe, often multivessel and distal.

Correct management of ACS and close collaboration between cardiologists and endocrinologists should improve prognosis for patients with diabetes.

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Primary angioplasty versus thrombolysis in ST elevation myocardial infarction

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Introduction: the treatment of ST segment elevation myocardial infarction is to restore permeability of the responsible coronary artery; the goal of our work is to illustrate the benefit of primary angioplasty as an alternative to thrombolysis.

Materials and methods: This is a retrospective study concerning 75 patients admitted for ST segment elevation myocardial infarction, between January 2008 and February 2010, divided into 2 groups: group [1] n=30, treated by primary angioplasty, compared to the group [2] n=45 thrombolysed.

Results: the average age of our patients is 56.6 ± 6.7 years (group 1) and 55.4 ± 5.9 years (group 2), male is predominant in the 2 groups, most of patients had more than 2 cardiovascular risk factors in the 2 groups.

The time between chest pain and admission to the emergency department is 231min in group 1 versus 247min in group 2, and the period of reperfusion is 281 min in group 1 (door to balloon) versus 277min (onset of chest pain to thrombolysis).

The coronary angiography showed three vessel lesions in 30% [group 1] versus 26% [Group 2], two vessel lesions in 23% [group 1] versus 18% [Group 2] and a single-vessel-disease in 47% [group 1] versus 56% [group 2].

In group 1, in addition to medical treatment and primary angioplasty, 3.3% had undergone coronary artery bypass grafting, in group 2, after thrombolysis, 24% benefited from angioplasty, 20% had CABG and 56% was treated medically.

Primary angioplasty has been marked by a primary success, the outcome was good in 83%, stent thrombosis occurred only in 2 cases.

In the second group, the outcome was favourable in only 46%, we deployed a single death due to cardiogenic shock and complications like left ventricular dysfunction in 13%, angina in 13% and arrhythmia in 3%.

Conclusion: the choice of basic therapy in STEMI is mainly based not only on accessibility to the angiography room but on angioplasty reperfusion (door to balloon), as well, when it is available, the angioplasty is highly recommended.